



General Assembly

January Session, 2017

Committee Bill No. 426

LCO No. 4813



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

**AN ACT CONCERNING CONTRACTS BETWEEN HEALTH CARRIERS
AND HEALTH CARE PROVIDERS, AGENTS OR VENDORS,
PARTICIPATING PROVIDER DIRECTORIES AND SURPRISE BILLS.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-477f of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2018*):

3 (a) On and after January 1, [2016] 2018, no contract entered into or
4 renewed between a health care provider, or any agent or vendor of a
5 health care provider, and a health carrier shall contain a provision
6 prohibiting disclosure of (1) billed or allowed amounts, reimbursement
7 rates or out-of-pocket costs, [and] or (2) any data to the all-payer
8 claims database program established under section 38a-1091. [for the
9 purpose of] Such information described in subdivisions (1) and (2) of
10 this subsection may be used for purposes such as assisting consumers
11 and institutional purchasers in making informed decisions regarding
12 their health care and informed choices among health care providers
13 and allow comparisons between prices paid by various health carriers
14 to health care providers.

15 (b) If a contract described in subsection (a) of this section contains a
16 provision prohibited under said subsection, the provision shall (1) be
17 void and unenforceable, and (2) constitute an unfair method of
18 competition and unfair or deceptive practice prohibited by sections
19 38a-815 to 38a-819, inclusive. The invalidity or unenforceability of any
20 contract provision under subdivision (1) of this subsection shall not
21 affect any other provision of the contract.

22 Sec. 2. Section 38a-477h of the general statutes is repealed and the
23 following is substituted in lieu thereof (*Effective October 1, 2017*):

24 (a) As used in this section: (1) "Covered person", "facility" and
25 "health carrier" have the same meanings as provided in section 38a-
26 591a, (2) "health care provider" has the same meaning as provided in
27 subsection (a) of section 38a-477aa, as amended by this act, and (3)
28 "intermediary", "network", "network plan" and "participating provider"
29 have the same meanings as provided in subsection (a) of section 38a-
30 472f.

31 (b) (1) Each health carrier shall post on its Internet web site a current
32 and accurate participating provider directory, updated at least
33 [monthly] weekly, for each of its network plans. The health carrier
34 shall ensure that [consumers are able to] any person may view,
35 without any restrictions or limitations, all of the current participating
36 providers for a network plan through a clearly identifiable link or tab
37 on such health carrier's Internet web site. [, without being required to
38 create or access an account or enter a policy or contract number.] The
39 directory shall be accessible without any requirement that the
40 individual seeking to access the directory (A) demonstrate coverage
41 under the underlying network plan, (B) indicate interest in obtaining
42 coverage under such plan, (C) create or access an account, (D) enter a
43 policy or contract number, or (E) provide any other personally
44 identifiable information.

45 (2) Each health carrier shall provide, upon request from [a covered]
46 any person, [or a covered person's representative,] a print copy of such

47 directory or of requested information from such directory. Such print
48 copy shall be provided to the person requesting such copy either (A) in
49 person, or (B) by mail postmarked not later than five business days
50 following the date of the request. Each health carrier shall update the
51 printed participating provider directory for each of its network plans
52 at least quarterly.

53 (3) Each contract between a health carrier and a provider
54 participating in a network plan shall require that the participating
55 provider inform the health carrier not later than five business days
56 after the date on which (A) the provider stops accepting new patients
57 enrolled in the plan, or (B) the provider begins accepting new patients
58 enrolled in the plan. Such contract shall provide the participating
59 provider with information and instructions on how to make such
60 notification through the online interface required under subsections (g)
61 and (h) of this section.

62 (c) (1) A health carrier shall include in each such electronic or print
63 directory the following information in plain language: (A) A
64 description of the criteria the health carrier used to build its network;
65 (B) if applicable, a description of the criteria the health carrier used to
66 tier its participating providers; (C) if applicable, a description of how
67 the health carrier designates the different participating provider tiers
68 or levels in the network and identifies, for each specific participating
69 provider, in which tier each is placed, such as by name, symbols or
70 grouping, to allow a consumer to be able to identify the participating
71 provider tiers; and (D) if applicable, a statement that authorization or
72 referral may be required to access some participating providers.

73 (2) Each such directory shall also include a customer service
74 electronic mail address, [and] telephone number [or] and an Internet
75 web site address that covered persons or consumers may use to
76 [notify] report to the health carrier [of] any inaccurate participating
77 provider information in such directory. The health carrier shall
78 promptly investigate any such report by, among other things,

79 contacting the affected health care provider not later than five business
80 days after submission of the report. The health carrier shall take
81 corrective action, if necessary, not later than thirty days after
82 submission of the report to ensure that the affected provider directory
83 is accurate.

84 (3) Each health carrier shall make it clear for each such electronic or
85 print directory which directory applies to which network plan, such as
86 by including the specific name of the network plan as marketed and
87 issued in this state.

88 (4) Each such electronic or print directory shall accommodate the
89 communication needs of individuals with disabilities and include an
90 Internet web site address or information regarding available assistance
91 for individuals with limited English proficiency.

92 (d) (1) The health carrier shall make available through an electronic
93 participating provider directory, for each of its network plans, the
94 following information in a searchable format:

95 (A) For health care providers, (i) the health care provider's name,
96 gender, participating office location or locations, specialty, if
97 applicable, medical group affiliations, if any, facility affiliations, if
98 applicable, participating facility affiliations, if applicable, (ii) any
99 languages other than English spoken by such health care provider, and
100 (iii) whether such health care provider is accepting new patients;

101 (B) For hospitals, the hospital name, the hospital type, such as acute,
102 rehabilitation, children's or cancer, the participating hospital location
103 and the hospital's accreditation status; and

104 (C) For facilities other than hospitals, by type, the facility name, the
105 facility type, the types of health care services performed at the facility
106 and the participating facility location or locations and telephone
107 number or numbers.

108 (2) In addition to the information required under subdivision (1) of

109 this subsection, the health carrier shall make available through the
110 electronic directory specified under subdivision (1) of this subsection,
111 for each of its network plans, the following information:

112 (A) For health care providers, the health care provider's contact
113 information, board certification and any languages other than English
114 spoken by clinical staff, if applicable;

115 (B) For hospitals, the hospital's telephone number; and

116 (C) For facilities other than hospitals, the facility's telephone
117 number.

118 (3) (A) Each health carrier shall make available in print, upon
119 request, the following participating provider directory information for
120 the applicable network plan:

121 (i) For health care providers, (I) the health care provider's name,
122 contact information, specialty, if applicable and participating office
123 location or locations, (II) any languages other than English spoken by
124 such health care provider, and (III) whether such health care provider
125 is accepting new patients;

126 (ii) For hospitals, the hospital name, the hospital type, such as acute,
127 rehabilitation, children's or cancer and the participating hospital
128 location and telephone number; and

129 (iii) For facilities other than hospitals, by type, the facility name, the
130 facility type, the types of health care services performed at the facility
131 and the participating facility location or locations and telephone
132 number or numbers.

133 (B) Each health carrier shall include with the print directory
134 information under subparagraph (A) of this subdivision and in the
135 print participating provider directory under subdivision (2) of
136 subsection (a) of this section a statement that the information provided
137 or included is accurate as of the date of printing, that covered persons

138 or prospective covered persons should consult the health carrier's
139 electronic participating provider directory on such health carrier's
140 Internet web site and that covered persons may call the telephone
141 number on such covered person's insurance card for more information.

142 (4) For the information required to be included in a participating
143 provider directory pursuant to subdivisions (1) and (2) of this
144 subsection, each health carrier shall make available through such
145 directory the sources of such information and any limitations on such
146 information, if applicable.

147 (e) Each health carrier shall, [periodically] at least annually, audit [at
148 least] a reasonable sample size of its participating provider directories
149 for accuracy and retain and provide documentation of such audit [to
150 be made available] to the commissioner upon request.

151 (f) Each health carrier shall report to the commissioner, in
152 accordance with timeframes and other requirements established by the
153 commissioner, but at least annually, (1) the number of reports the
154 health carrier received under subdivision (2) of subsection (c) of this
155 section, the name and location of each provider affected by each such
156 report, a description of the nature and timeliness of the carrier's
157 investigation into each such report, and the corrective action taken, if
158 any, in response to each such report, and (2) information concerning
159 the most recent audit conducted pursuant to subsection (e) of this
160 section including, but not limited to, the methodology, sample size and
161 findings thereof, and the responses thereto.

162 (g) Each health carrier shall take appropriate steps to ensure that the
163 information contained in its provider directories is accurate and shall,
164 at least annually, conduct a comprehensive review of the directory for
165 each of its network plans. Each health carrier, as part of such
166 comprehensive review, shall update and send written notice to each
167 participating provider concerning (1) the processes the health carrier
168 uses to notify each participating provider of the information contained
169 in the directory, (2) the information contained in the directory

170 concerning the provider, (3) instructions concerning the process by
171 which each such provider can update or correct such information
172 using an online interface, and (4) a list of all network plans that include
173 the provider as a participating provider.

174 (h) Each health carrier shall implement processes to allow providers
175 to promptly verify and submit changes to the information in provider
176 directories. Such processes shall, at a minimum, include an online
177 interface for providers to electronically submit verification of changes
178 and shall generate an acknowledgment of receipt of such verification
179 from the health carrier.

180 (i) If a covered person reasonably relied upon materially inaccurate,
181 incomplete or misleading information contained in a health carrier's
182 participating provider directory concerning health care services
183 provided to such covered person, the health carrier shall cover all
184 health care services provided to such covered person as covered
185 services as if such inaccurate, incomplete or misleading information
186 were correct and shall reimburse such covered person for any costs
187 that exceed the costs the covered person would have incurred had the
188 services been provided by a participating provider.

189 Sec. 3. Section 38a-477aa of the general statutes is repealed and the
190 following is substituted in lieu thereof (*Effective January 1, 2018*):

191 (a) As used in this section:

192 (1) "Emergency condition" has the same meaning as "emergency
193 medical condition", as provided in section 38a-591a;

194 (2) "Emergency services" means, with respect to an emergency
195 condition, (A) a medical screening examination as required under
196 Section 1867 of the Social Security Act, as amended from time to time,
197 that is within the capability of a hospital emergency department,
198 including ancillary services routinely available to such department to
199 evaluate such condition, [and] (B) such further medical examinations

200 and treatment required under said Section 1867 to stabilize such
201 individual, that are within the capability of the hospital staff and
202 facilities, and (C) any further medically necessary hospital services
203 provided as part of the same continuous episode of care and admission
204 to treat the emergency condition;

205 (3) "Health care plan" means an individual or a group health
206 insurance policy or health benefit plan that provides coverage of the
207 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
208 469;

209 (4) "Health care provider" means an individual licensed to provide
210 health care services under chapters 370 to 373, inclusive, chapters 375
211 to 383b, inclusive, and chapters 384a to 384c, inclusive;

212 (5) "Health carrier" means an insurance company, health care center,
213 hospital service corporation, medical service corporation, fraternal
214 benefit society or other entity that delivers, issues for delivery, renews,
215 amends or continues a health care plan in this state;

216 (6) (A) "Surprise bill" means a bill for health care services, other than
217 emergency services, received by an insured for services rendered by an
218 out-of-network health care provider, where such services were
219 rendered by such out-of-network provider (1) at an in-network facility,
220 (2) during a service or procedure performed by an in-network
221 provider, (3) or during a service or procedure previously approved or
222 authorized by the health carrier, [and the insured did not knowingly
223 elect to obtain such services from such out-of-network provider] or (4)
224 upon the referral of an in-network provider and without the express
225 written consent of the insured acknowledging that the in-network
226 provider is referring the insured to an out-of-network provider and
227 that the referral may cause the insured to incur costs not covered by
228 the health carrier.

229 (B) "Surprise bill" does not include a bill for health care services
230 received by an insured when an in-network health care provider was

231 made available to the insured to render such services and the insured
232 knowingly [elected] and voluntarily consented, in writing, to obtain
233 such services from another health care provider who was out-of-
234 network and acknowledged, in writing, that such services might result
235 in costs not covered by the health carrier. For scheduled health care
236 services, a health care provider shall obtain such written consent when
237 the provider first discovers that the provider is an out-of-network
238 provider or immediately before such services are rendered, whichever
239 shall occur first.

240 (b) (1) No health carrier shall require prior authorization for
241 rendering emergency services to an insured.

242 (2) No health carrier shall impose, for emergency services rendered
243 to an insured by an out-of-network health care provider, a
244 coinsurance, copayment, deductible or other out-of-pocket expense
245 that is greater than the coinsurance, copayment, deductible or other
246 out-of-pocket expense that would be imposed if such emergency
247 services were rendered by an in-network health care provider.

248 (3) (A) If emergency services were rendered to an insured by an out-
249 of-network health care provider, such health care provider may bill the
250 health carrier directly and the health carrier shall, within five days,
251 reimburse such health care provider the greatest of the following
252 amounts: (i) The amount the insured's health care plan would pay for
253 such services if rendered by an in-network health care provider; (ii) the
254 usual, customary and reasonable rate for such services; or (iii) the
255 amount Medicare would reimburse for such services. As used in this
256 subparagraph, "usual, customary and reasonable rate" means the
257 eightieth percentile of all charges for the particular health care service
258 performed by a health care provider in the same or similar specialty
259 and provided in the same geographical area, as reported in a
260 benchmarking database maintained by a nonprofit organization
261 specified by the Insurance Commissioner. Such organization shall not
262 be affiliated with any health carrier.

263 (B) Nothing in this subdivision shall (i) be construed to prohibit
264 such health carrier and out-of-network health care provider from
265 agreeing to a greater reimbursement amount, or (ii) constitute a waiver
266 of any right of either party, including any right to dispute the
267 reimbursement provided pursuant to this subdivision.

268 (c) With respect to a surprise bill:

269 (1) An insured shall only be required to pay the applicable
270 coinsurance, copayment, deductible or other out-of-pocket expense
271 that would be imposed for such health care services if such services
272 were rendered by an in-network health care provider; and

273 (2) [A] (A) An out-of-network provider may bill the health carrier
274 directly for the services rendered. The health carrier shall, not later
275 than thirty days after the out-of-network health care provider rendered
276 such services, reimburse the out-of-network health care provider [or
277 insured, as applicable,] for the health care services rendered [at the in-
278 network rate under the insured's health care plan as payment in full,
279 unless such health carrier and health care provider agree otherwise] at
280 the billed amount or, if the health carrier determines that the billed
281 amount is unreasonable, an amount that is not less than the average in-
282 network rate paid to similarly qualified health care providers for the
283 same services in the same region.

284 (B) Nothing in this subdivision shall (i) be construed to prohibit a
285 health carrier or out-of-network health care provider from agreeing to
286 a different reimbursement amount, or (ii) constitute a waiver of any
287 right of either party, including any right to dispute the reimbursement
288 provided pursuant to this subdivision.

289 (d) If health care services were rendered to an insured by an out-of-
290 network health care provider and the health carrier failed to inform
291 such insured, if such insured was required to be informed, of the
292 network status of such health care provider pursuant to subdivision (3)
293 of subsection (d) of section 38a-591b, the health carrier shall not impose

294 a coinsurance, copayment, deductible or other out-of-pocket expense
295 that is greater than the coinsurance, copayment, deductible or other
296 out-of-pocket expense that would be imposed if such services were
297 rendered by an in-network health care provider.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2018</i>	38a-477f
Sec. 2	<i>October 1, 2017</i>	38a-477h
Sec. 3	<i>January 1, 2018</i>	38a-477aa

Statement of Purpose:

To (1) prohibit contracts between health carriers and health care providers, or agents or vendors of health care providers, from proscribing disclosure of certain information, (2) require that health carriers maintain accurate, current and detailed preferred provider directories, and (3) restrict surprise bills for health care services.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: SEN. LOONEY, 11th Dist.; SEN. FASANO, 34th Dist.

S.B. 426